Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
8108 FOX CREEK TRAIL
DALLAS TX 75249

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Date Received

OCTOBER 24, 2011

MFDR Tracking Number

M4-12-0592-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No EOB/Preauthorized - # PH622286. No EOB received. Billed at MAR fee guidelines."

Amount in Dispute: $8,426.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC-60 form from the Requestor lists the dispute as a fee dispute and involves physical therapy and a chronic pain management program in which all dates of service have been paid with the exception of 2/14/11."

Respondent's Payment Summary: Supports position that all services were paid except February 14, 2011

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2010 through February 11, 2011	CPT Codes 97032, 97035, 97110, 97112, 97140, 99213 and 97799CP	$8,026.86	$0.0
February 14, 2011	CPT Code 97799-CP (4 hours)	$400.00	$200.00
TOTAL		$8,426.86	$200.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 12, 2010
   - 320-Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - 38-Services not provided or authorized by designated (network/primary care) providers.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 857-This service has been allowed at the request of the carrier.
   - 888-Disallowed: Our records indicate that this procedure was not authorized by Intracorp based on medical necessity.
   - B12-Re-evaluated; additional payment recommended.
   - W1-Workers compensation jurisdictional fee schedule adjustment.

   Explanation of benefits dated June 7, 2011
   - W1-Workers compensation state fee schedule adjustment

Issues

1. Is the requestor entitled to reimbursement for dates of service November 2, 2010 through February 11, 2011?
2. Is the requestor entitled to reimbursement for date of service February 14, 2011?

Findings

1. The respondent states in the position summary that "The DWC-60 form from the Requestor lists the dispute as a fee dispute and involves physical therapy and a chronic pain management program in which all dates of service have been paid with the exception of 2/14/11."

   The respondent submitted a copy of a payment summary that supports the requestor has been paid for all services in dispute except the chronic pain management rendered on February 14, 2011.
2. 28 Texas Administrative Code §134.600 (p)(10), states "Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   The respondent gave preauthorization for 10 visits (80 hours) of chronic pain management program with a start date of January 20, 2011 and end date of February 28, 2011.

   The preauthorization report indicates that 80 hours of chronic pain management were preauthorized.

   A review of the submitted medical bill indicates that the requestor rendered 82 hours of chronic pain management. The payment supports that the requestor has been paid for 78 hours; therefore, the requestor is entitled to reimbursement of 2 hours of chronic pain management.

   28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   >
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

Per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times two hours is $200.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $200.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $200.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		1/17/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.